



## PHYSICIAN PROGRESS NOTES

Patient Name Boyd Courtney I.D. # 208921 Institution \_\_\_\_\_

DATE	TIME	NOTES	SIGNATURE
2/13/03		<p>wt. 143 lbs</p> <p>B/P 120/80 P 80 R 20 T 96°</p> <p>S: My Stomach hurts. I have a bump on my face</p> <p>O: Tenderness mid epigastric Region ⊕ small 4 quadrants  tenderness to palpation in lower quadrants  Integument - firming Abscess chin 10mm induration</p> <p>A: H. Pylor ⊕ test</p> <p>Tormentil Abscess</p> <p>P: Tetracycline 500mg TPO tid x 14 days  Repto Bisul tablets 2 po tid x 14 days  Zantac 150mg TPO BID x 14 days  Flagyl 500mg TPO BID x 14 days  Red &amp; blood stool, ↑ pain &amp; fever</p>	
2-18-03		<p>CG 15 <u>wt. 132</u>; 112/80; 80; 18; 96°; 97% <u>21 gm</u> on</p> <p>S: <u>weight loss</u> - 20 lb weight loss in past month. Appetite OK. No sick</p> <p>Q: <u>Denies</u> IDU.</p> <p>S: <u>don't</u> but <u>spice</u> like - I must go "bust" himself</p> <p>O: 16x - w/low w/d on - <u>don't</u> have cholelithiasis CV-RS no mts</p> <p>A: abd - no mts, no BS</p> <p>S: <u>Wt loss</u> ? etiology. (Hed ⊕ PPD send with)</p> <p>O: <u>hears</u> will give cholelithiasis</p>	<p>Chubb, MD</p>
2/28/03	9 AM	<p>138 118/70 69 18 97.5</p> <p>S: I am having a h/a, stomach ache, unless multiple complaints</p> <p>O: Pt will be referred to Dr. Kelby, pt continues to argue about double triglyceride and its alteration will not stop arguing. Unable to redirect pt</p>	<p>Dr. Kelby</p> <p>Dr. Kelby</p>

NaphCare

Physician's  
Progress Notes

date	Time	Notes Must Be Signed By Physician
05/18/01		S: C/o ④ lateral + ant chest pain "sharp - comes + goes" Not assoc. i movement, breathing, exertion. ④ n/v ④ diaphoresis. ④ meds O: Smiling, laughing A+O, NAD Heart: RRR - ④ m Lungs: clear A+P, resp easy + nonlabored Skin: WRO, cap refill < 3 sec. Chest: ④ lateral + ant chest i ? tenderness i palp (unable to assess due to pt inconsistent i affect + level of pain) A: ④ chest pain P: no EKG - 5/18/01 RTC pm — m. Bell CRNR
2/20/03	12:12p	C/O Abnormal A/R - VIS by sat 98 - P 86, BP 110/68 R 22. Pt is alert, no visible signs of SOB. cyanosis Pt c/o h/o h/o his vision
2/11/03	1325	⑤ I feel like my blood pressure is up and I'm having a heart attack. ⑥ A/Ox3. No distress noted. Resp even/calm. Skin color - wnl; w/ll to touch. Neuro assessment - wnl; Bilat equal pup - pERRA; No diaphoresis, cyanosis noted; No S/S of numbness to exte. N/A W/C steady gait. No 90 finding to extremities. No 90 HAs or chest pain. No SOB noted. ⑦ assessment per DOC ⑧ BP taken 106/70 @ this time; advised to follow sick call procedure for further C/O; No other shift of care for EL ————— Nurse CRF
2-24-03	12AM	⑤ "My mouth is numb from Minox," ⑥ Alert + OX3. Skin W/D to touch. Resp. even & non-labored. O2 Sat. 99%, ⑦ 2nd WNL. Abdomen soft, non-tender, non-distended. ⑧ x4. Cap. refill < 3 seconds. ⑨ sit norm 4:30am Appetite good. Ate two trays. No acute distress. ⑩ Altered comfort ⑪ 23° observation. ⑫ Notify nurse when ready to leave ————— Buncham R
Name - Last		First
Brynd		Courtney
Middle		Inmate No
		208921

Physician's Progress Notes

□ Continued on Reverse

NCOC



# DEPARTMENT OF CORRECTIONS TRANSFER & RECEIVING SCREENING FORM

RECEIVED: Inmate/Health Record

Institution: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

RECEIVED FROM: \_\_\_\_\_

Institution/Work Release Center/Free-World Hospital

## RECEIVING MEDICAL STATUS

☐ Population☐ Infirmary☐ Isolation

RELEASED: Inmate/Health Record

Institution: KilbyDate: 5/8/04 Time: 5 pm AM/PM

RELEASE FROM: \_\_\_\_\_

☐ Infirmary☐ Segregation☒ Population☐ Mental Health☐ Other \_\_\_\_\_

RELEASE TO: \_\_\_\_\_

☒ DOC☐ Infirmary☐ Mental Health☐ \_\_\_\_\_

Institution/Work Release Center/Free-World Hospital

ALLERGIES: \_\_\_\_\_

## PHYSICAL EXAMINATION

Date of last exam: 3/3/01

Chest X-Ray Date: \_\_\_\_\_ Result: \_\_\_\_\_

PPD Reading 3/3/02 0 0mm

Classification: \_\_\_\_\_

Limitations: \_\_\_\_\_

## LAB RESULTS - - LAST REPORT

CBC

Urinalysis

Date

Normal

Abnormal

☒☐☒☐☐☐Wears Glasses/Contacts ☐Dental Prosthesis ☐Hearing Aide ☐Other Prosthesis ☐

YES

NO

☐☐☐☐☐☐☐☐

Receiving Nurse: \_\_\_\_\_

## CURRENT OR CHRONIC MEDICAL/DENTAL/MENTAL HEALTH PROBLEMS OR COMPLAINTS

Is in prison for 4 years

## CURRENT MEDICATION - - DOSAGE AND FREQUENCY

MEDICATIONS

☐ Sent w / inmate☐ Not sent w / inmate

X-RAY FILM

☐ Sent w / inmate☐ Not sent w / inmate

HEALTH RECORD

☒ Sent w / inmate☐ Not sent w / inmate

Released to: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

MEDICATIONS

☐ Received☐ Not Received

X-RAY FILM

☐ Received☐ Not Received

HEALTH RECORD

☐ Received☐ Not Received

## SCHEDULE FOR CHRONIC CARE CLINIC

DATE: \_\_\_\_\_ LAST CLINIC: \_\_\_\_\_

CHART REVIEWED

☐ YES☐ NO

Received by: \_\_\_\_\_

Signature of Receiving Nurse

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

## FOLLOW-UP CARE NEEDED

Date

Time

With Whom - - Location (Sending Nurse)

Date/Appt. Made w/Whom (Rec. Nurse)

☐ Medical☐ Dental☐ Mental HealthNURSING ASSESSMENT (SENDING NURSE)  
(Noted from health record documentation)

	Yes	No
HISTORY		
Drug Use		<input checked="" type="checkbox"/>
Mental Illness		<input checked="" type="checkbox"/>
Suicide Attempt		<input checked="" type="checkbox"/>
Chronic Care		<input checked="" type="checkbox"/>

STATUS	Special Diet		
	Appearance		<input checked="" type="checkbox"/>

OTHER PERTINENT NURSING ASSESSMENT

NURSING ASSESSMENT (RECEIVING NURSE)  
(Noted from inmate assessment)

	Yes	No
SKIN		
Open Sores		
Lice		
Edema		
Warm & Dry		
Cool & Moist		

CONDITION	Alert		
	Oriented		
	Uncooperative		
	Depressed		

## INTAKE

Sick Call Procedures Explained \_\_\_\_\_

Height \_\_\_\_\_

Weight \_\_\_\_\_

Blood Pressure \_\_\_\_\_

Temperature \_\_\_\_\_

Pulse Resp. \_\_\_\_\_

Other \_\_\_\_\_

Angela Jackson, RN  
Signature of Nurse Completing Assessment (Sending Nurse)

Date

Signature of Intake Screening Nurse (Receiving Nurse)

Date

INMATE NAME (LAST, FIRST, MIDDLE)

ROYN CARNEY

DOC#

208921

DOB

Race/Sex

Bm

FAC.

KILBY



# DEPARTMENT OF CORRECTIONS TRANSFER & RECEIVING SCREENING FORM

RECEIVED: Inmate/Health Record

Institution: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

RECEIVED FROM:

Institution/Work Release Center/Free-World Hospital

RELEASED: Inmate/Health Record

Institution: ELMOREDate: 3-17-04 Time: 430 AM/PM

RELEASE FROM:

- ☐ Infirmary    ☐ Segregation  
☒ Population    ☐ Mental Health  
☐ Other \_\_\_\_\_

RELEASE TO:

- ☐ DOC    ☐ Infirmary    ☐ Mental Health  
☒ Kelby

Institution/Work Release Center/Free-World Hospital

ALLERGIES:

PHYSICAL EXAMINATION

Date of last exam: \_\_\_\_\_

Chest X-Ray Date: \_\_\_\_\_ Result: \_\_\_\_\_

PPD Reading 3-21-03 φ

Classification: \_\_\_\_\_

Limitations: \_\_\_\_\_

RECEIVING MEDICAL STATUS

- ☐ Population  
☐ Infirmary  
☐ Isolation

LAB RESULTS - - LAST REPORT

	Date	Normal	Abnormal
CBC	_____	<input type="checkbox"/>	<input type="checkbox"/>
Urinalysis	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

Wears Glasses/Contacts ☒ YES ☐ NO  
 Dental Prosthesis ☐ YES ☐ NO  
 Hearing Aide ☐ YES ☐ NO  
 Other Prosthesis ☐ YES ☐ NO

YES ☒ NO ☐  
Ready  
Colinda Tyner  
 Receiving Nurse

CURRENT OR CHRONIC MEDICAL/DENTAL/MENTAL HEALTH PROBLEMS OR COMPLAINTS

CURRENT MEDICATION - - DOSAGE AND FREQUENCY

MEDICATIONS ☐ Sent w / inmate ☒ Not sent w / inmate  
 X-RAY FILM ☐ Sent w / inmate ☒ Not sent w / inmate  
 HEALTH RECORD ☒ Sent w / inmate ☒ Not sent w / inmate  
 Released to: Kelby

Date: 3-17-04 Time: 430 AM/PM

MEDICATIONS ☐ Received ☒ Not Received  
 X-RAY FILM ☐ Received ☒ Not Received  
 HEALTH RECORD ☒ Received ☐ Not Received

SCHEDULE FOR CHRONIC CARE CLINIC

DATE: \_\_\_\_\_ LAST CLINIC: \_\_\_\_\_

CHART REVIEWED ☒ YES ☐ NOReceived by: Colinda Tyner  
Signature of Receiving NurseDate: 3/11/04 Time: 1735 AM/PM

FOLLOW-UP CARE NEEDED

Date

Time

With Whom - - Location (Sending Nurse)

Date/Appt. Made w/Whom (Rec. Nurse)

☐ Medical ☐ Dental☐ Mental HealthNURSING ASSESSMENT (SENDING NURSE)  
(Noted from health record documentation)

	Yes	No
HISTORY		
Drug Use		<input checked="" type="checkbox"/>
Mental Illness		<input checked="" type="checkbox"/>
Suicide Attempt		<input checked="" type="checkbox"/>
Chronic Care		<input checked="" type="checkbox"/>

STATUS		
Special Diet		<input checked="" type="checkbox"/>
Appearance		

OTHER PERTINENT NURSING ASSESSMENT

NURSING ASSESSMENT (RECEIVING NURSE)  
(Noted from inmate assessment)

	Yes	No
SKIN		
Open Sores		<input checked="" type="checkbox"/>
Lice		<input checked="" type="checkbox"/>
Edema		<input checked="" type="checkbox"/>
Warm & Dry		<input checked="" type="checkbox"/>
Cool & Moist		<input checked="" type="checkbox"/>

CONDITION		
Alert		<input checked="" type="checkbox"/>
Oriented		<input checked="" type="checkbox"/>
Uncooperative		<input checked="" type="checkbox"/>
Depressed		<input checked="" type="checkbox"/>

INTAKE

Sick Call Procedures Explained ☒Height 5'8Weight 150Blood Pressure 110/76Temperature 98.8Pulse Resp. 88 20

Other \_\_\_\_\_

Signature of Nurse Completing Assessment (Sending Nurse)

Date

Signature of Intake Screening Nurse (Receiving Nurse)

Date

INMATE NAME (LAST, FIRST, MIDDLE)

DOC#

DOB

Race/Sex

FAC.

Boyd, Courtney20892BMCELMORE

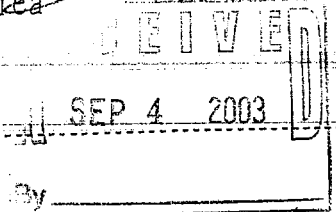
CynaphCare, Inc.

## Health Services Request Form

Inmate Name Mr. [Signature] Boyd Date of Request 9-3-03AIS No. 208921 Date of Birth [Redacted] Housing Loc. D-3-29TNature of problem or request I need to see the doctor for the following things:  
1. my back is hurting, also I lost 15 pounds in 2 weeks. And left  
eye is in pain.Sign here for consent to be treated by health staff for the condition described above. [Signature] Boyd

Place this slip in Medical Box or designated area

DO NOT WRITE BELOW THIS LINE



Health Care Documentation

Subjective:

WaiverObjective: BP \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ T \_\_\_\_\_ WT 137

Assessment:

Plan:

Refer to: ☒ PA/Physician ☐ Mental Health ☐ Dental

Education: \_\_\_\_\_

Protocol used: (specify) \_\_\_\_\_

Signature [Signature] Title LPN Time 11:37pm Date 9-4-03

GraphCare, Inc.

## Health Services Request Form

Inmate Name Courtney ByrdDate of Request D-325JS No. 20842Date of Birth [REDACTED]Housing Loc. D-729TNature of problem or request Back problem, and heart problem, lost 15  
pounds + two weeks.Sign here for consent to be treated by health staff for the condition described above. [Signature]

Place this slip in Medical Box or designated area.

DO NOT WRITE BELOW THIS LINE

RECEIVED SEP 24 2003

## Health Care Documentation

Subjective:

"I have Back Pain x heart Problems x 3 mos  
O<sub>2</sub> Sat 98%

Objective:

BP 110/88 P 98 R 20 T 92.6 WT 144

Assessment:

Inmate examined lungs clear Hx regular  
Alteration in comfort  
Refer to M.D.[Signature]

Referral to: PA/Physician

Mental Health

Dental

Referral to:

Referral used: (specify)

[Signature]

Time

1:00

Time

10:30

Date

9-24-03



RECEIVED SEP 17 2001

GraphCare, Inc.

## Health Services Request Form

Inmate Name: Coleman, BayaDate of Request 9-17-03JS No. 208921Date of Birth [REDACTED]Housing Loc. D-3-297Nature of problem or request My back has been giving me problems.Sign here for consent to be treated by health staff for the condition described above. Coleman, Baya

Place this slip in Medical Box or designated area

DO NOT WRITE BELOW THIS LINE

## Health Care Documentation

Subjective:

Objective:

BP

P

R

T

WT

Waiver

Assessment:

Plan:

Referral to:

PA/Physician

Mental Health

Dental

Location:

Protocol used: (specify)

Title

Time

Date

GraphCare, Inc.  
Health Services Request Form

Inmate Name Mr. Courtney BlyDate of Request 8-13-03JS No. 268471Date of Birth [REDACTED]Housing Loc. D-729T

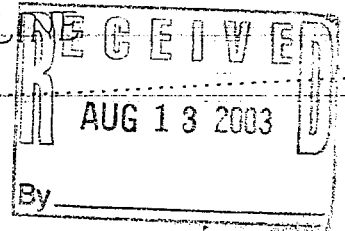
Nature of problem or request I need to see the doctor about my back problem, and about my weight it's still dropping, and my left eye.

Sign here for consent to be treated by health staff for the condition described above. Courtney Bly

Place this slip in Medical Box or designated area

DO NOT WRITE BELOW THIS LINE

Health Care Documentation



Subjective:

Weight loss of 15 lbs, since 2 weeks ago. Ⓛ eye has blurry vision, I need my paracosics back for my back. And my double portic BP 102/68 P 55 R 20 T 97.0 WT 145

Presented to infirmary with back pain rated 10 on a 1-10 scale. Eye problem for 3-4 days. PERRLA. Ⓛ eye 20/70 on eye chart.

Assessment:

Alteration in comfort

Plan:

Refer to MD.

Refer to:

PA/Physician

Mental Health

Dental

Education:

Warm compresses for back pain. No heavy lifting. No strenuous exercise. No sports.

Tool used: (specify)

Ⓛ backache

Signature [Signature]

Title \_\_\_\_\_

Time \_\_\_\_\_

Date \_\_\_\_\_



VaphCare, Inc.

Health Services Request Form

Inmate Name Courtney Byrd Date of Request 4-14-03

JS No. 208921 Date of Birth [REDACTED] Housing Loc. D-3-29T

Nature of problem or request I have been problem with my back for over  
two months. Request to see doctor

Sign here for consent to be treated by health staff for the condition described above. Courtney Byrd

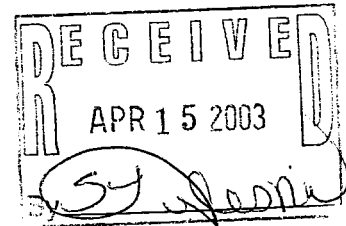
Place this slip in Medical Box or designated area

DO NOT WRITE BELOW THIS LINE

Health Care Documentation

Subjective:

"My back hurts - for over  
two months -"



Objective: BP 100/60 P 66 R 20 T 97.2 WT 133

Pain rated 6 on 1-10 scale.

Assessment: Altered comfort

Plan: Refer to MD.

Refer to: PA/Physician Mental Health Dental

Education: No heavy lifting, No strenuous activity.  
No sports.

Referral used: (specify) back ache  
Signature M. Bingham Title RN Time 11:00 Date 4-15-03

GraphCare, Inc

## Health Services Request Form

Inmate Name Courtney R. Smith Date of Request 8-5-03AIS No. 208921 Date of Birth [REDACTED] Housing Loc. D-2-29TNature of problem or request MY MOUTH AND I lost weight in the last TWO days. ALSO the last 24 hrs I have been nauseous.Sign here for consent to be treated by health staff for the condition described above. Courtney R. Smith

Place this slip in Medical Box or designated area

DO NOT WRITE BELOW THIS LINE

Health Care Documentation

Subjective:

"My jaw feels like its coming loose when I chew. Hit it on the rail of my bed. 3 or 4 days ago.

Objective: BP 90/60 P 62 R 20 T 97.3 WT 122

Presented to infirmary with pain rated 10 on (-10 scale).

Assessment: Altered comfort due to S/S of dislocated mandible.

Plan: Refer to MD.

Refer to: PA Physician

Mental Health

Dental

Education: Patient educated per pain management technique. Also discussed possible x-ray & treatment.

Protocol used (specify)

Signature M. M. Bingham Title RA Time 10:45 Date 8-6-03

DEPARTMENT OF CORRECTIONS  
**TRANSFER & RECEIVING SCREENING FORM**

<b>RECEIVED: Inmate/Health Record</b> Institution: <u>Elmore</u> Date: <u>12/21/03</u> Time: <u>7</u> <u>AM/PM</u> RECEIVED FROM: Institution/Work Release Center/Free-World Hospital	<b>RELEASED: Inmate/Health Record</b> Institution: <u>Bibb</u> Date: <u>12-18-03</u> Time: _____ AM/PM RELEASE FROM: <input type="checkbox"/> Infirmary <input type="checkbox"/> Segregation <input checked="" type="checkbox"/> Population <input type="checkbox"/> Mental Health <input type="checkbox"/> Other _____ RELEASE TO: <input checked="" type="checkbox"/> DOC <input type="checkbox"/> Infirmary <input type="checkbox"/> Mental Health <input checked="" type="checkbox"/> <u>Elmore</u> <u>Elmore</u> Institution/Work Release Center/Free-World Hospital	<b>ALLERGIES:</b> <u>NKA</u> <b>PHYSICAL EXAMINATION</b> Date of last exam: <u>3-21-03</u> Chest X-Ray Date: _____ Result: _____ PPD Reading <u>3-21-03 - 0</u> Classification: _____ Limitations: <u>none</u>
<b>RECEIVING MEDICAL STATUS</b> <input checked="" type="checkbox"/> Population <input type="checkbox"/> Infirmary <input type="checkbox"/> Isolation		

<b>LAB RESULTS - - LAST REPORT</b>			
CBC	Date: <u>10-9-03</u>	Normal <input checked="" type="checkbox"/>	Abnormal <input type="checkbox"/>
Urinalysis		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		Wears Glasses/Contacts <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
		Dental Prosthesis <input type="checkbox"/>	<input checked="" type="checkbox"/>
		Hearing Aide <input type="checkbox"/>	<input checked="" type="checkbox"/>
		Other Prosthesis <input type="checkbox"/>	<input checked="" type="checkbox"/>
			<input checked="" type="checkbox"/> Receiving Nurse

CURRENT OR CHRONIC MEDICAL/DENTAL/MENTAL HEALTH PROBLEMS OR COMPLAINTS

CURRENT MEDICATION - - DOSAGE AND FREQUENCY

MEDICATIONS ☐ Sent w / inmate ☒ Not sent w / inmate  
 X-RAY FILM ☐ Sent w / inmate ☒ Not sent w / inmate  
 HEALTH RECORD ☐ Sent w / inmate ☐ Not sent w / inmate  
 Released to: Elmore

Date: 12-18-03 Time: \_\_\_\_\_ AM/PM

MEDICATIONS ☐ Received ☒ Not Received  
 X-RAY FILM ☐ Received ☒ Not Received  
 HEALTH RECORD ☒ Received ☐ Not Received  
 CHART REVIEWED ☒ YES ☐ NO

Received by: Wall Smith  
Signature of Receiving NurseDate: 12/21/03 Time: 7 AM/PM

SCHEDULE FOR CHRONIC CARE CLINIC

DATE: \_\_\_\_\_ LAST CLINIC: \_\_\_\_\_

FOLLOW-UP CARE NEEDED

☐ Medical ☐ Dental  
☐ Mental Health

Date

Time

With Whom - - Location (Sending Nurse)

Date/Appt. Made w/Whom (Rec. Nurse)

NURSING ASSESSMENT (SENDING NURSE)  
(Noted from health record documentation)

	Yes	No
HISTORY		
Drug Use		<input checked="" type="checkbox"/>
Mental Illness		<input checked="" type="checkbox"/>
Suicide Attempt		<input checked="" type="checkbox"/>
Chronic Care		<input checked="" type="checkbox"/>

STATUS		
Special Diet		<input checked="" type="checkbox"/>
Appearance		<input checked="" type="checkbox"/>

OTHER PERTINENT NURSING ASSESSMENT

NURSING ASSESSMENT (RECEIVING NURSE)  
(Noted from inmate assessment)

	Yes	No
SKIN		
Open Sores		<input checked="" type="checkbox"/>
Lice		<input checked="" type="checkbox"/>
Edema		<input checked="" type="checkbox"/>
Warm & Dry	<input checked="" type="checkbox"/>	
Cool & Moist	<input checked="" type="checkbox"/>	

CONDITION		
Alert	<input checked="" type="checkbox"/>	
Oriented	<input checked="" type="checkbox"/>	
Uncooperative		<input checked="" type="checkbox"/>
Depressed		<input checked="" type="checkbox"/>

INTAKE

Sick Call Procedures Explained 4  
 Height 5'9"  
 Weight 145  
 Blood Pressure 120/80  
 Temperature 97.6  
 Pulse Resp. 80-20  
 Other \_\_\_\_\_

S. J. Inman LPN  
 Signature of Nurse Completing Assessment (Sending Nurse)

Date

Signature of Intake Screening Nurse (Receiving Nurse)

Date

INMATE NAME (LAST, FIRST, MIDDLE)

DOC#

DOB

Race/Sex

FAC.

BOYD Courtney208921[REDACTED]B/mBibb

Name	Last <u>Boyd</u> First <u>Courtney</u> Middle Initial	AIS #	<u>208921</u>
Date	<u>12-12-03</u> Allergies <u>NKA</u>	Facility	<u>B1bb</u>
SIG.	1) mintoX in tabs Rx - now	Discontinue	<u>noted</u>
		Continue	<u>12-12-03</u>
		Increase	<u>2 B1bb</u>
Physician Signature:	<u>V.D. Ar. Mosier / [Signature]</u>	Decrease	

NC002

Muggins, Cnp

Name	Last <u>Boyd</u> First <u>Courtney</u> Middle Initial	AIS #	<u>208921</u>
Date	<u>12-16-03</u> Allergies <u>NKA</u>	Facility	<u>B1bb</u>
SIG.	<u>PE B10X 60 days</u>	Discontinue	<u>M Mosier / [Signature]</u>
	<u>V.D. Ar. Mosier / [Signature]</u>	Continue	<u>12-16-03</u>
		Increase	<u>1451 [Signature]</u>
Physician Signature:	<u>Muggins, Cnp</u>	Decrease	

NC002

Name	Last <u>Boyd</u> First <u>Courtney</u> Middle Initial	AIS #	<u>208921</u>
Date	<u>10/9/03</u> Allergies <u>[Signature]</u>	Facility	<u>B1bb</u>
SIG.	1) CBC, CMP (14) Repeat 14 days	Discontinue	<u>Noted</u>
	2) Penicillin 2 tabs TID PRN x 45 days	Continue	<u>10-10-03</u>
	3) Zantac 150mg BID x 60 days	Increase	<u>[Signature]</u>
Physician Signature:	<u>[Signature]</u>	Decrease	

NC002

4) Double zantac x 30 days 0.15 x 2 @ [Signature] R10 04

Name	Last <u>Boyd</u> First <u>Courtney</u> Middle Initial	AIS #	<u>208921</u>
Date	<u>12/16/03</u> Allergies <u>[Signature]</u>	Facility	<u>B1bb</u>
SIG.	<u>possible for [Signature]</u>	Discontinue	<u>noted</u>
	<u>was a [Signature] now you [Signature]</u>	Continue	<u>9/24/03</u>
		Increase	<u>@ 920</u>
Physician Signature:	<u>[Signature]</u>	Decrease	

Name	<sup>Last</sup> <u>Bryd</u> <sup>First</sup> <u>Courtney</u> <sup>Middle Initial</sup>	AIS #	<u>208921</u>
Date	<u>9/9/03</u> Allergies <u>NKA</u>	Facility	<u>Bublo</u>
SIG.	<u>Zyfernel 325mg ti tabs po</u> <u>TID x 4 days</u> <u>100mg 150mg upon w</u>	Discontinue	
Physician Signature:	<u>[Signature]</u>	Continue	
		Increase	
		Decrease	

NC002

Name	<sup>Last</sup> <u>Bryd</u> <sup>First</sup> <u>Courtney</u> <sup>Middle Initial</sup>	AIS #	<u>208921</u>
Date	<u>8/6/03</u> Allergies <u>NKA</u>	Facility	<u>BW</u>
SIG.	<u>1) Weigh power x3</u> <u>2) Then cft</u>	Discontinue	
Physician Signature:	<u>[Signature]</u>	Continue	<u>MMiller</u> <u>8-6-03</u> <u>11:35AM</u>
		Increase	
		Decrease	

NC002

Name	<sup>Last</sup> <u>Bryd</u> <sup>First</sup> <u>Courtney</u> <sup>Middle Initial</sup>	AIS #	<u>208921</u>
Date	<u>7-1-03</u> Allergies	Facility	<u>BW</u>
SIG.	<u>1) Bactrim (later not filled) - TID - R/O</u> <u>2) Bactrim 7 available x 30 days</u> <u>3) D/K Penicillin</u>	Discontinue	
Physician Signature:	<u>[Signature]</u>	Continue	<u>7/2/03</u> <u>1:30 PM</u>
		Increase	
		Decrease	

NC002

Name	<sup>Last</sup> <u>Bryd</u> <sup>First</sup> <u>Courtney</u> <sup>Middle Initial</sup>	AIS #	<u>208921</u>
Date	<u>6/15/03</u> Allergies	Facility	<u>BW</u>
SIG.	<u>1) T cldown R/O gas - R/O gelatin</u> <u>2) Bactrim 7 available x 30 days</u> <u>3) D/K Penicillin</u>	Discontinue	
Physician Signature:	<u>[Signature]</u>	Continue	<u>6-10-03</u>
		Increase	
		Decrease	

Name	<sup>Last</sup> Boyd <sup>First</sup> Courtney <sup>Middle Initial</sup>	AIS #	208921
Date	6/19/03 Allergies	Facility	BIBB
SIG.	1) US of abdomen - supposedly done 1-2 weeks ago - Reported negative, please find & report. 2) Spine is negative, order CT scan 3) Cat's Double Portion x 30 days	Discontinue Continue Increase Decrease	
Physician Signature:			

NC002

Name	<sup>Last</sup> Boyd Courtney <sup>First</sup> <sup>Middle Initial</sup>	AIS #	208921
Date	6/13/03 Allergies NKA	Facility	BIBB
SIG.	Bottom Back profile x 3 days only - no dizziness / lightheaded. RDR. Delany / Skumacher	Discontinue Continue Increase Decrease	Noted 6/13/03 0830 Skumacher
Physician Signature:			

NC002

Name	<sup>Last</sup> Boyd <sup>First</sup> Courtney <sup>Middle Initial</sup>	AIS #	208921
Date	5/7/03 Allergies	Facility	BIBB
SIG.	1) Cat's - DOUBLE PORTION meals x 30 days 2) Wght gain x 4 weeks 3) 20 c 1 month 4) GI const - 7 enemas	Discontinue Continue Increase Decrease	Noted A. King 5/7/03 6:50 pm
Physician Signature:			
5) this - no gall stones 6) CMP, Hepatic panel, Angiogram, Spine			

NC002

Name	<sup>Last</sup> Boyd <sup>First</sup> Courtney <sup>Middle Initial</sup>	AIS #	208921
Date	4/17/03 Allergies NKA	Facility	BIBB
SIG.	Appr	Discontinue Continue Increase Decrease	Noted 4/17/03 450
Physician Signature:			

NC002



Name	Last <u>Boyd</u> First <u>Courtney</u> Middle Initial	AIS #	<u>208921</u>
Date	<u>2/28/03</u> Allergies <u>0</u>	Facility	<u>Bibb</u>
SIG. <u>① appt = Dr Delong</u>		Discontinue	<u>Noted</u>
		Continue	<u>K. Delong</u>
		Increase	<u>2-28-03</u>
		Decrease	<u>@ 2:50 pm</u>
Physician Signature: <u>Chell</u>			

NC002

Name	Last <u>Boyd</u> First <u>Courtney</u> Middle Initial	AIS #	<u>208921</u>
Date	<u>2/27/03</u> Allergies <u>0</u>	Facility	<u>Bibb</u>
SIG. <u>① Mental Health Consult pt with multiple somatic complaints</u>		Discontinue	<u>Noted</u>
		Continue	<u>Chell</u>
		Increase	<u>2/27/03</u>
		Decrease	
Physician Signature: <u>Chell</u>			

NC002

Name	Last <u>Boyd</u> First <u>Courtney</u> Middle Initial	AIS #	<u>208921</u>
Date	<u>2/25/03</u> Allergies <u>NKA</u>	Facility	<u>Bibb</u>
SIG. <u>Hydral PRN tid x 3 days</u> <u>W/O Dr Delong / E. Smither</u>		Discontinue	<u>E. Smither</u>
		Continue	<u>2/25/03</u>
		Increase	<u>9:20 pm</u>
		Decrease	
Physician Signature: <u>Chell</u>			

NC002

Name	Last <u>Boyd</u> First <u>Courtney</u> Middle Initial	AIS #	<u>208921</u>
Date	<u>2/25/03</u> Allergies <u>NKA</u>	Facility	<u>Bibb</u>
SIG. <u>LS spine X-ray</u>		Discontinue	<u>Noted</u>
		Continue	<u>2/26/03</u>
		Increase	<u>@ 2:10 pm</u>
		Decrease	<u>Chell</u>
Physician Signature: <u>Dr Delong</u>			

Name <sup>Last</sup> <u>Boyd</u> <sup>First</sup> <u>Courtney</u> <sup>Middle Initial</sup>	AIS # <u>208921</u>
Date <u>2/25/03</u> Allergies <u>None</u>	Facility <u>Bibb</u>
SIG. <u>1) Cancel Double tap (altered link slip) from 30 days to 80 days</u>	Discontinue <u>noted</u>
Physician Signature: <u>Ch Helberg</u>	Continue <u>2/25/03 2:00 PM</u>
	Increase <u>None</u>
	Decrease <u>None</u>

NC002

Name <sup>Last</sup> <u>Boyd</u> <sup>First</sup> <u>Courtney</u> <sup>Middle Initial</sup>	AIS # <u>208921</u>
Date <u>2/18/03</u> Allergies <u>NKA</u>	Facility <u>Bibb</u>
SIG. <u>1) CBC, CMP (14), TB, Ty, HIV</u>	Discontinue <u>noted</u>
<u>2) Please get free world record - Dr Dzanke / Davis</u>	Continue <u>2/18/03</u>
<u>3) DOUBLE TAP x 30 days - 21 just right loss</u>	Increase <u>@ 5:20 PM</u>
Physician Signature: <u>Ch Helberg</u>	Decrease <u>S. Taylor</u>

NC002

Name <sup>Last</sup> <u>Boyd</u> <sup>First</sup> <u>Courtney</u> <sup>Middle Initial</sup>	AIS # <u>208921</u>
Date <u>1/8/03</u> Allergies <u>None</u>	Facility <u>Bibb</u>
SIG. <u>1) appt re. Spiderbites</u>	Discontinue <u>noted</u>
Physician Signature: <u>Ch Helberg</u>	Continue <u>1/8/03</u>
	Increase <u>5:20 PM</u>
	Decrease <u>S. Taylor</u>

NC002

Name <sup>Last</sup> <u>Boyd, Courtney</u> <sup>First</sup> <u>Courtney</u> <sup>Middle Initial</sup>	AIS # <u>208921</u>
Date <u>1/7/03</u> Allergies <u>NKA</u>	Facility <u>Bibb</u>
SIG. <u>1) Motion coming pax &amp; x2 days</u>	Discontinue <u>noted</u>
Physician Signature: <u>Ch Helberg</u> <u>1/8/03</u> <u>0800</u>	Continue <u>1/7/03</u>
	Increase <u>2:57 PM</u>
	Decrease <u>S. Taylor</u>



## PHYSICIANS' ORDERS

NAME:	DIAGNOSIS (If Chg'd)
D.O.B. / /	
ALLERGIES:	
Use Last Date / /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME:	DIAGNOSIS (If Chg'd)
D.O.B. / /	
ALLERGIES:	
Use Fourth Date / /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME:	DIAGNOSIS (If Chg'd)
D.O.B. / /	
ALLERGIES:	
Use Third Date / /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME:	DIAGNOSIS (If Chg'd)
D.O.B. / /	
ALLERGIES:	
Use Second Date / /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: Boyd, Courtney Station 28208921	DIAGNOSIS Bactrim DS - po BID x 10 days place in form inmate
D.O.B. [REDACTED]	
ALLERGIES: NK	
Use First Date 10/18/09	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED



## PHYSICIANS' ORDERS

NAME: Boyd, Courtney  
208921

D.O.B. [REDACTED]

ALLERGIES: NKA

Use Last

Date 8/13/04

DIAGNOSIS (If Chg'd)

wt ✓ 9 mo x 6 months

Back Brace x 6 months ✓

Naprosyn 325mg po qd x 14 days ✓

HCU visit 2 months f/u Back pain

noted 8/14/04 [unclear]

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

appt. 10/12/04 ✓

NAME: Boyd, Courtney  
208921

D.O.B. [REDACTED]

ALLERGIES:

Use Fourth

Date 8/6/04

DIAGNOSIS (If Chg'd)

HCU f/u for Back Pain / Abd pain

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Boyd, Courtney  
208921

D.O.B. [REDACTED]

ALLERGIES:

Use Third

Date 6/4/04

DIAGNOSIS (If Chg'd) LBP

Back brace x 60 days

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Boyd, Courtney  
208921

D.O.B. [REDACTED]

ALLERGIES: NKA

Use Second

Date 5/28/04

DIAGNOSIS (If Chg'd)

HCU visit today [unclear]

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Boyd, Courtney  
208921

D.O.B. [REDACTED]

ALLERGIES: NKA

Use First

Date 5/18/04

DIAGNOSIS LBP - request back brace

pt may have back brace x 90 days  
Motrin 600mg BID x 5 days

☐ GENERIC SUBSTITUTION IS NOT PERMITTED



# PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: Courtney Byrd Date of Request: 6-2-04  
 ID # 208921 Date of Birth: [REDACTED] Location: A-7-97  
 Nature of problem or request: I have been having problems with my  
right arm with my rib and my back. This is my third time  
complaining about these problems.

Courtney Byrd  
Signature

DO NOT WRITE BELOW THIS LINE

Date: 6/3/04  
 Time: 6:10 AM PM  
 Allergies: NKA

<p>RECEIVED</p> <p>Date: _____</p> <p>Time: _____</p> <p>Receiving Nurse Initials _____</p>
---

(S)ubjective: Need back brace I more took it, Bbb  
gone it for 30 days

(O)bjective (V/S): T: 98.3 P: 68 R: 20 BP: 110/70 WT: 168

Alert skin w/o resp ease ambulatory 3  
difficulty good ROM & swelling & tenderness

(A)ssessment: Alteration in comfort

(P)lan: MD to Review

Refer to: MD PA Mental Health Dental Daily Treatment Return to Clinic PRN  
 CIRCLE ONE

Check One: ROUTINE (✓) EMERGENCY ( )

If Emergency was PHS supervisor notified: Yes ( ) No (✓)

Was MD/PA on call notified: Yes ( ) No (✓)

Alt Smith Lpn

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



# PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: Courtesy Blair Date of Request: 5-16-04  
 ID # 202921 Date of Birth: [REDACTED] Location: A-3-95  
 Nature of problem or request: I have been have back pain, and I need my back brace back because it help out

Courtesy Blair  
Signature

DO NOT WRITE BELOW THIS LINE

Date: 5/17/04  
 Time: 8:20 AM ☒ PM  
 Allergies: 2

<p>RECEIVED          Date: <u>5/16/04</u>          Time: <u>7:20pm</u>          Receiving Nurse Initials <u>SD</u></p>
--

Refer to Sick Call

(S)ubjective: Back Brace work on farm my back be hurting too bad

(O)bjective (V/S): T: 97.4 P: 80 R: 20 BP: 110/70 WT: 165  
Complained of pain center of back ambulatory  
5 difficulty good ROM

(A)ssessment:

Alteration in comfort

5/18/04  
(MS)  
8

(P)lan:

MD to Review

Refer to: ☒ MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN  
 CIRCLE ONE

Check One: ROUTINE ( ☒ ) EMERGENCY ( )

If Emergency was PHS supervisor notified: Yes ( ) No ( ☒ )  
 Was MD/PA on call notified: Yes ( ) No ( ☒ )

Alt Smith Jr

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT





# PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: Courtesy Boyd Date of Request: 7-29-04  
 ID # 208421 Date of Birth: [REDACTED] Location: A-3-9T  
 Nature of problem or request: I have been have leg problems and back problems, and my right arm is hurting. Also I had got bacteria and my stomach from eating some meat out of the kitchen at bibb Co. Corr. Fac. and now my stomach is in serious pain. Also I lost 20 pounds in two weeks.  
Courtesy Boyd  
 Signature

DO NOT WRITE BELOW THIS LINE

Date:    /   /     
 Time:     AM PM  
 Allergies:    

RECEIVED	
Date:	<u>29 July</u>
Time:	<u>8:50 PM</u>
Receiving Nurse Initials	<u>RO</u>

NO  
SHOW

(S)ubjective:

(O)bjective (V/S): T:     P:     R:     BP:     WT:    

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN  
 CIRCLE ONE

Check One: ROUTINE ( ) EMERGENCY ( )

If Emergency was PHS supervisor notified: Yes ( ) No ( )

Was MD/PA on call notified: Yes ( ) No ( )

B. Oum

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

Stadm

**PRISON HEALTH SERVICES, INC.  
SICK CALL REQUEST**

Print Name: Courtney Bay Date of Request: 5-12-04  
 ID # 208921 Date of Birth: [REDACTED] Location: A-3-97  
 Nature of problem or request: I have been having back problems.

[Signature]  
Signature

**DO NOT WRITE BELOW THIS LINE**

Date:    /    /     
 Time:    AM PM  
 Allergies:   

<p align="center"><b>RECEIVED</b></p> <p>Date: <u>  </u></p> <p>Time: <u>  </u></p> <p>Receiving Nurse Initials <u>  </u></p>
---

**(S)ubjective:**

*No Show*

**(O)bjective** (V/S): T:    P:    R:    BP:    WT:   

**(A)ssessment:**

**(P)lan:**

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN

CIRCLE ONE

Check One: ROUTINE ( ) EMERGENCY ( )

If Emergency was PHS supervisor notified: Yes ( ) No ( )

Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



**PRISON HEALTH SERVICES, INC.  
SICK CALL REQUEST**

Print Name: Donkey Bay Date of Request: 5-12-04  
ID # 208921 Date of Birth: [REDACTED] Location: A-7-97  
Nature of problem or request: I have been having back problems.

[Signature]  
Signature

**DO NOT WRITE BELOW THIS LINE**

Date:    /    /     
Time:    AM    PM  
Allergies:   

<p align="center"><b>RECEIVED</b></p> <p>Date: <u>  </u> / <u>  </u> / <u>  </u></p> <p>Time: <u>  </u> AM <u>  </u> PM</p> <p>Receiving Nurse Initials <u>  </u></p>
---

**(S)ubjective:**

**(O)bjective**    **(V/S):** T:       P:       R:       BP:       WT:   

**(A)ssessment:**

**(P)lan:**

Refer to: MD/PA    Mental Health    Dental    Daily Treatment    Return to Clinic PRN

CIRCLE ONE

Check One: ROUTINE ( )    EMERGENCY ( )

If Emergency was PHS supervisor notified: Yes ( )    No ( )

Was MD/PA on call notified: Yes ( )    No ( )

    
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



Follow up

# PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: Courtney Boyd Date of Request: 2-10-05  
 ID # 208921 Date of Birth: [REDACTED] Location: C-2-95  
 Nature of problem or request: I need to get my new back brace, and profile. ALSO my eyes are st. 'll giving me problems. I need some TOP CRANE I need to see the DOCTOR about my back giving me pain.

[Signature]  
Signature

DO NOT WRITE BELOW THIS LINE

Date: 02/11/05  
 Time: 7:30 AM PM  
 Allergies: NKA

RECEIVED
Date: _____
Time: _____
Receiving Nurse Initials _____

(S)ubjective: I need a new back brace, renew profiles, & eye.

(O)bjective (V/S): T: 97.6 P: 72 R: 18 BP: 100/58 WT: 165  
Requests new back brace, has been issued some before. Noted stye to T & eyelid. Requests eye gts. & drainage & penicillin

(A)ssessment: Alertness in Comfort

(P)lan: 1/2 hr to review

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN  
 CIRCLE ONE

Check One: ROUTINE (☒) EMERGENCY ( )

If Emergency was PHS supervisor notified: Yes ( ) No ( )

Was MD/PA on call notified: Yes ( ) No ( )

[Signature]  
SIGNATURE AND TITLE

2-11-05

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



# PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: Courtney Blyde Date of Request: 11-11-04  
 ID # 208921 Date of Birth: [REDACTED] Location: A-3-97  
 Nature of problem or request: I need to have my double tray profile  
renew and my back is still giving me problems, my eye are  
giving me problems as well.  
Request to see the Doctor.  
Courtney Blyde  
 Signature

DO NOT WRITE BELOW THIS LINE

Date: 11/12/04  
 Time: 1900 AM ☒ PM  
 Allergies: NKDA

RECEIVED	
Date: <u>11-12-04</u>	
Time: <u>1900</u>	
Receiving Nurse Initials	<u>WZ</u>

(S)ubjective: "I need a double portion I am  
losing weight. I'm still having problems with  
my back. My eye is still swollen."

(O)bjective (V/S): T: 97 P: 60 R: 16 BP: 112/60 WT: 140  
O2 stat 94% Ambulating 3 difficulty  
R eye dilation & small amt of swelling noted  
S/S of acute distress noted.

(A)ssessment:  
Alteration in comfort

(P)lan: Up to Review

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN  
 CIRCLE ONE

Check One: ROUTINE ( ) EMERGENCY ( )

If Emergency was PHS supervisor notified: Yes ( ) No ( )

Was MD/PA on call notified: Yes ( ) No ( )

[Signature]  
 SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

Handwritten note:  
11/11/04



[illegible]

Facility Name:	Month/Year of Charting																																							
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31								
Pericosis: Cti' po	4p																																							
b: d po x 14 days	4p																																							
	Start Date:	3/30/06										Prescriber:	R. Arbay																											
	Stop Date:	4/13/06										RX #:																												
Pericosis: 1/2 po	4p																																							
310 po x 30 days	4p																																							
	Start Date:	4/12/06										Prescriber:	D. L. Bourke Jr.																											
	Stop Date:	5/21/06										RX #:																												
	Start Date:											Prescriber:																												
	Stop Date:											RX #:																												
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	Stop Date:											RX #:																												
Diagnosis	NKA										Nurse's Signature										Initial										Documentation Codes									
Allergies	NKDA										S. B. [Signature]										S. B.										1. Discontinued Order									
Housing Unit	208521										[Signature]										[Signature]										2. Refused									
Patient ID Number																															3. Patient out of facility									
Patient Name																															4. Charted in Error									
																															5. Lock Down									
																															6. Self Administered									
																															7. Medication out of Stock									
																															8. Medication Held									
																															9. No Show									

ECF

3/02

1.	Discontinued Order
2.	Refused
3.	Patient out of facility
4.	Charted in Error
5.	Lock Down
6.	Self Administered
7.	Medication out of Stock
8.	Medication Held
9.	No Show

Facility Name:																																	
	Tylenol 50mg X 2 PO BID X 5 days	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		4pm																S/S	S/S	S/S	/												
		4am																<i>[Signature]</i>															
		Start Date: 3-11-2006										Prescriber: Dase IDr																					
		Stop Date: 3-16-2006										RX #:																					
	MAR 10 X TAD II PO BID X 5 days	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		4pm																S/S	S/S	S/S	/												
		4am																<i>[Signature]</i>															
		Start Date: 3-11-2006										Prescriber: Dase IDr																					
		Stop Date: 3-16-2006										RX #:																					
		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		Start Date:										Prescriber:																					
		Stop Date:										RX #:																					
		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		Start Date:										Prescriber:																					
		Stop Date:										RX #:																					
		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		Start Date:										Prescriber:																					
		Stop Date:										RX #:																					
		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		Start Date:										Prescriber:																					
		Stop Date:										RX #:																					
		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		Start Date:										Prescriber:																					
		Stop Date:										RX #:																					

Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Codes
Allergies LKA	<i>[Signature]</i>	LK	<i>[Signature]</i>	db	1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock 8. Medication Held 9. No Show
Housing Unit:					
Patient ID Number: 20P121					
Patient Name:					



Facility Name	Month/Year of Charting: March																																																	
Adriel Young Now the Tid 7 3day	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	3																		
	Start Date:	3/24/06										Prescriber: Dr. Darbaze																																						
	Stop Date:	3/27/06										RX #:																																						
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	3																		
	Start Date:											Prescriber:																																						
	Stop Date:											RX #:																																						
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	3																		
	Start Date:											Prescriber:																																						
	Stop Date:											RX #:																																						
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	3																		
	Start Date:											Prescriber:																																						
	Stop Date:											RX #:																																						
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	3																		
	Start Date:											Prescriber:																																						
	Stop Date:											RX #:																																						
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	3																		
	Start Date:											Prescriber:																																						
	Stop Date:											RX #:																																						
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	3																		
	Start Date:											Prescriber:																																						
	Stop Date:											RX #:																																						
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	3																		
	Start Date:											Prescriber:																																						
	Stop Date:											RX #:																																						
Diagnosis	Nurse's Signature										Initial										Nurse's Signature										Initial										Documentation Codes									
Allergies	NKDA																																								1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock 8. Medication Held 9. No Show									
Housing Unit:																																																		
Patient ID Number:	208921																																																	
Patient Name:																																																		

Facility Name: <u>Easterling</u>		Month/Year of Charting: <u>Nov 05</u>																														
Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Tylenol tid 1 gm po x 7d	4a																															
	9a																															
	4p																															
Start Date: <u>11-7-05</u>		Prescriber: <u>Danbury</u>																														
Stop Date: <u>11-14-05</u>		RX #:																														
Mylantra 2 tabs po bid tid x 7d	4a																															
	9a																															
	4p																															
Start Date: <u>11-7-05</u>		Prescriber: <u>Danbury</u>																														
Stop Date: <u>11-14-05</u>		RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Start Date:		Prescriber:																													
Stop Date:		RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Start Date:		Prescriber:																													
Stop Date:		RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Start Date:		Prescriber:																													
Stop Date:		RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Start Date:		Prescriber:																													
Stop Date:		RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Start Date:		Prescriber:																													
Stop Date:		RX #:																														

Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Codes
Allergies <u>NKA</u>	<u>[Signature]</u>	<u>CS</u>	<u>[Signature]</u>	<u>EW</u>	1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock 8. Medication Held 9. No Show
Housing Unit:					
Patient ID Number: <u>208921</u>					
Patient Name:					





Facility Name:	Month/Year of Charting:	Hour																														
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Motrin 600mg po tid x 30 days PR	4A																															
	4P																															
Start Date: 8-22-05		Prescriber: Darbouze																														
Stop Date: 9-22-05		RX #:																														
mycolog oint topically Bid x 14 days PR	4A																															
	4P																															
Start Date: 8-23-05		Prescriber: Darbouze																														
Stop Date: 9-5-05		RX #:																														
Naalox 300 po tid x 7 days	4A																															
	4P																															
Start Date: 9/6/05		Prescriber: Darbouze/MLP																														
Stop Date: 9/13/05		RX #:																														
Zantac 150mg ÷ po bid x 14 days	4A																															
	4P																															
Start Date: 9/6/05		Prescriber: Darbouze/MLP																														
Stop Date: 9/20/05		RX #:																														
	4A																															
	4P																															
Start Date:		Prescriber:																														
Stop Date:		RX #:																														
	4A																															
	4P																															
Start Date:		Prescriber:																														
Stop Date:		RX #:																														
	4A																															
	4P																															
Start Date:		Prescriber:																														
Stop Date:		RX #:																														
Diagnosis	Nurse's Signature		Initial		Nurse's Signature		Initial		Documentation Codes																							
Allergies NKA	B. Brown R		P		C. McKinnis L		CM		1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock 8. Medication Held 9. No Show																							
Housing Unit:																																
Patient ID Number: # 208921																																
Patient Name:																																

Facility Name: <i>E/mare</i>		Month/Year of Charting: <i>Received Easterling 8-17-05</i>																														
Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
TAD apply to groin rash													<i>dispense 1 tube</i> <i>8-17-05</i> <i>le packets given</i> <i>Prescriber: [Signature]</i> <i>RX #: [Blank]</i>																			
		Start Date: <i>8-11-05</i>																														
		Stop Date: [Blank]																														
Motrin 600mg po. TID. X 60 days  <i>KOP</i>		<i>6A</i> <i>12N</i> <i>6P</i> <i>Start Date: 8-11-05</i> <i>Prescriber: [Signature]</i> <i>Stop Date: 9-11-05</i> <i>RX #: [Blank]</i>																														
		Hour																														
Motrin 600mg ÷ po tid pen x 30 days		<i>4a</i> <i>9a</i> <i>4p</i> <i>Start Date: 8/22/05</i> <i>Prescriber: Darbany/MP</i> <i>Stop Date: 9/22/05</i> <i>RX #: [Blank]</i>																														
		Hour																														
Mycellog oint bid pen x 14 days		<i>4a</i> <i>4p</i> <i>Start Date: 8/22/05</i> <i>Prescriber: Darbany/MP</i> <i>Stop Date: 9/5/05</i> <i>RX #: [Blank]</i>																														
		Hour																														
		<i>Start Date: [Blank]</i> <i>Prescriber: [Blank]</i> <i>Stop Date: [Blank]</i> <i>RX #: [Blank]</i>																														
		Hour																														
		<i>Start Date: [Blank]</i> <i>Prescriber: [Blank]</i> <i>Stop Date: [Blank]</i> <i>RX #: [Blank]</i>																														
		Hour																														

Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Codes
	<i>[Signature]</i>	<i>[Initial]</i>	<i>[Signature]</i>	<i>[Initial]</i>	1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock 8. Medication Held 9. No Show
Allergies					
Housing Unit: <i>E/mare</i>					
Patient ID Number: <i>208921</i>					
Patient Name: <i>[Signature]</i>					



STD T01

[illegible]

# MEDICATION ADMINISTRATION RECORD

STD701

MEDICATIONS		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
Keflex 500mg PO BID X 14 days 4/28/05 - 5/11/05	6 11 6																												
metronidazole 600mg PO BID X 10 days 4/28/05 - 5/7/05	6 11 6																												
penicillamine PO BID X 3 days 5/18/05 - 5/21/05	6 11 6																												

**NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE**

CHARTING FOR

THROUGH

Physician

Alt. Physician

Telephone No. \_\_\_\_\_

Medical Record No. \_\_\_\_\_

Alt. Telephone

Rehabilitative  
Potential

### Diagnosis

## Medicaid Nursing

Medicare Number

Complete Entries Checked:

By:

Title:

Date \_\_\_\_\_

4/28

# MEDICATION ADMINISTRATION RECORD

STD01

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
4/5/05 Keftex 500mg p.o. TID x 14 days	6A 12N 6P																															
04.13.05 Nortri 600mg po TID x 70	6A 12N 6P																															
04/20/05 D. McArthur Keftex 500mg po TID x 14 days 4/28/05 - 5/11/05	6A 12N 6P																															
Nortri 600mg po BID x 10 days 4/28/05 - 5/7/05	6A 12N 6P																															

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE																															
CHARTING FOR 04/01/05 THROUGH 04/30/05																															
Physician D. Williams, M.D.																Telephone No.															
Alt. Physician J. Jassiter, RN, CRNP																Alt. Telephone															
Allergies NKA																Rehabilitative Potential															
Diagnosis																															
Medicare Number																Medicare Number															
Complete Entries Checked: [Signature]																Title: RN															
By: [Signature]																Date: 4/5/05															
PATIENT CODE																ROOM NO.															
BED																FACILITY															



# MEDICATION ADMINISTRATION RECORD

STUDY

[illegible]

**NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE**

CHARTING FOR		THROUGH
Physician		Telephone No.
Alt. Physician <i>Lassiter CRPA</i>		Alt. Telephone
Nurses <i>NRA</i>		Rehabilitative Potential

Diagnosis:			
Medicaid Number:	Medicare Number:	Complete Entries Checked:	
		By: <i>M. Knight</i>	Title: <i>RN</i>
		Date: <i>2/21</i>	
Patient Code	Room No.	Per Lead	



# MEDICATION ADMINISTRATION RECORD

STC350

[illegible][illegible]

MEDICATIONS										NONE										1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28									
NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE																													
CHARTING FOR 02.02.05 THROUGH 02.28.05																													
Physician <i>Dr. Williams</i>															Telephone No.										Medical Record No.				
Alt. Physician <i>L. Russell CRNP</i>															Alt. Telephone														
Languages <i>NKA</i>															Rehabilitative Potential														
Diagnosis																													
Medication Number										Medicine Number										Complete Entries Checked									
																				By: <i>M. Alan</i>									
																				Title: <i>L</i>									
																				Date: 02.02.05									
																				REDUCED									

# MEDICATION ADMINISTRATION RECORD

[illegible]

KILBY CORRECTIONAL FAC  
PO BOX 11  
MT. MEIGS, AL 36057

PATIENT NAME

Boyd, Courtney  
PRISON ID  
208921

DATE SUBMITTED

12-28-04

SEC 161

TEST NAME	RESULT	REFERENCE RANGE	COMMENTS
HIV ANTIBODY		NEGATIVE (NEG)	
RPR	NR	NON-REACTIVE (NR)	
URINALYSIS			
APPEARANCE			
pH		pH 5- pH 6	
PROTEIN		NEGATIVE (NEG)	
GLUCOSE		NEGATIVE (NEG)	
KETONES		NEGATIVE (NEG)	
BILIRUBIN		NEGATIVE (NEG)	
BLOOD		< 5 RBC/MCL	
NITRITE		NEGATIVE (NEG)	
UROBILINOGEN		< 1.0 MG/DL	
LEUK. ESTERASE		NEGATIVE (NEG)	
SPECIFIC GRAVITY		1.016-1.022	

"A" These results are unreliable due to the age of the specimen.

"H" These results are unreliable due to the hemolyzed condition of the specimen.

"A+H" These results are unreliable due to the age and hemolyzed condition of the specimen.





## STUDY

[illegible]

# MEDICATION ADMINISTRATION RECORD

55551

MEDICATIONS		DATE	TIME	DOSE	ROUTE	EFFECT	ADVERSE REACTIONS	COMMENTS
		8-14-04 - 2/14/05						
		10/08/04 Bactrim DS ÷ P.O.						
		Bid x 10 days						
		10/18/04 L. Lassitu chafed skin						

**NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE**

CHARTING FOR 10/1/04 THROUGH 10/31/04

Physician	Telephone No.	Medical Record No.
-----------	---------------	--------------------

Alt. Physician	Alt. Telephone
----------------	----------------

Energy: MKA Rehabilitative Potential

Medicare Number: Medicare Number: Complete Entries Checked:

By: [Signature] Title: Chief Date: 9/29/11

DATE	DESCRIPTION	AMOUNT	BALANCE
1/1/20	OPENING BALANCE		100.00
1/15/20	PAYROLL	50.00	150.00
2/1/20	RENT	200.00	350.00
2/15/20	PAYROLL	50.00	400.00
3/1/20	RENT	200.00	600.00
3/15/20	PAYROLL	50.00	650.00
4/1/20	RENT	200.00	850.00
4/15/20	PAYROLL	50.00	900.00
5/1/20	RENT	200.00	1100.00
5/15/20	PAYROLL	50.00	1150.00
6/1/20	RENT	200.00	1350.00
6/15/20	PAYROLL	50.00	1400.00
7/1/20	RENT	200.00	1600.00
7/15/20	PAYROLL	50.00	1650.00
8/1/20	RENT	200.00	1850.00
8/15/20	PAYROLL	50.00	1900.00
9/1/20	RENT	200.00	2100.00
9/15/20	PAYROLL	50.00	2150.00
10/1/20	RENT	200.00	2350.00
10/15/20	PAYROLL	50.00	2400.00
11/1/20	RENT	200.00	2600.00
11/15/20	PAYROLL	50.00	2650.00
12/1/20	RENT	200.00	2850.00
12/15/20	PAYROLL	50.00	2900.00
1/1/21	RENT	200.00	3100.00
1/15/21	PAYROLL	50.00	3150.00
2/1/21	RENT	200.00	3350.00
2/15/21	PAYROLL	50.00	3400.00
3/1/21	RENT	200.00	3600.00
3/15/21	PAYROLL	50.00	3650.00
4/1/21	RENT	200.00	3850.00
4/15/21	PAYROLL	50.00	3900.00
5/1/21	RENT	200.00	4100.00
5/15/21	PAYROLL	50.00	4150.00
6/1/21	RENT	200.00	4350.00
6/15/21	PAYROLL	50.00	4400.00
7/1/21	RENT	200.00	4600.00
7/15/21	PAYROLL	50.00	4650.00
8/1/21	RENT	200.00	4850.00
8/15/21	PAYROLL	50.00	4900.00
9/1/21	RENT	200.00	5100.00
9/15/21	PAYROLL	50.00	5150.00
10/1/21	RENT	200.00	5350.00
10/15/21	PAYROLL	50.00	5400.00
11/1/21	RENT	200.00	5600.00
11/15/21	PAYROLL	50.00	5650.00
12/1/21	RENT	200.00	5850.00
12/15/21	PAYROLL	50.00	5900.00
1/1/22	RENT	200.00	6100.00
1/15/22	PAYROLL	50.00	6150.00
2/1/22	RENT	200.00	6350.00
2/15/22	PAYROLL	50.00	6400.00
3/1/22	RENT	200.00	6600.00
3/15/22	PAYROLL	50.00	6650.00
4/1/22	RENT	200.00	6850.00
4/15/22	PAYROLL	50.00	6900.00
5/1/22	RENT	200.00	7100.00
5/15/22	PAYROLL	50.00	7150.00
6/1/22	RENT	200.00	7350.00
6/15/22	PAYROLL	50.00	7400.00
7/1/22	RENT	200.00	7600.00
7/15/22	PAYROLL	50.00	7650.00
8/1/22	RENT	200.00	7850.00
8/15/22	PAYROLL	50.00	7900.00
9/1/22	RENT	200.00	8100.00
9/15/22	PAYROLL	50.00	8150.00
10/1/22	RENT	200.00	8350.00
10/15/22	PAYROLL	50.00	8400.00
11/1/22	RENT	200.00	8600.00
11/15/22	PAYROLL	50.00	8650.00
12/1/22	RENT	200.00	8850.00
12/15/22	PAYROLL	50.00	8900.00
1/1/23	RENT	200.00	9100.00
1/15/23	PAYROLL	50.00	9150.00
2/1/23	RENT	200.00	9350.00
2/15/23	PAYROLL	50.00	9400.00
3/1/23	RENT	200.00	9600.00
3/15/23	PAYROLL	50.00	



## MEDICATION ADMINISTRATION RECORD

STD01

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Naproxen 375 mg + po qd x 14 days 8-14-04 → 8-28-04	6a															CAN 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30															
Back Brace x 6 months 8-14-04 → 2-14-05	9/19/04 ms C. B. B.																														

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30										
NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE																																									
CHARTING FOR 8-14-04 THROUGH 8-31-04																																									
Physician																Telephone No.																Medical Record No.									
Alt. Physician L. L. L.																Alt. Telephone																									
Diagnosis NKDA																Rehabilitative Potential																									
Medication Number																Medication Number																Complete Entries Checked:									
By: [Signature]																Title:																Date:									
PATIENT CODE																ROOM NO.																BED FACILITY									

# MEDICATION ADMINISTRATION RECORD

STD T01

SCC

## MEDICATIONS

Pericardare ÷ Bid  
130 days  
1/20/04 - 2/20/04

6A B B H H M B B B L B N B B B B B  
B B B B B B B B B B B B B B

## MEDICATIONS

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR

Physician

Alt. Physician

## Allergies

## Diagnosis

Medical Number

[illegible]

Complete entries checked:

By:

Title

Date:

PATIENT

CONFIDENTIAL

## ROMANIA

FACTS

7-100

# MEDICATION ADMINISTRATION RECORD

SCC

Mag Citrate 1 Bottle 6A  
 9 AM x 2 days  
 1/20/04 - 1/22/04

1741

Pericolace 1 BID 6A  
 x 30 days 6P  
 1/20/04 - 2/20/04

1. A 1-AB 100  
 1. B 100 100 100 100

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29

REVISIONS

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 1/1/04 THROUGH 1/31/04

Physician Sonner  
 AP Physician

208921

Signature

Signature

Signature

Complete Entries Checked:

By: T. Hampton

Title: NPH

Date: 1/20/04  
 50..

NOTE: Rick ...

# MEDICATION ADMINISTRATION RECORD

STDT01

[illegible]

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE																														
CHARTING FOR 6/1/04 THROUGH 6/30/04																														
Physician Dr. Sommer																		Telephone No.						Medical Record No. 208921						
Alt. Physician																		Alt. Telephone												
Nurses																		Rehabilitative Potential												
Diagnosis																														
Medical Number						Nursing Number						Complete Entries Checked:																		
By: T. Hampton						Title: LPN						Date: 6/4/04																		
PATIENT: Boyd, Christopher						PATIENT CODE: 208921						ROOM NO.						BED						FACILITY: CH						



# MEDICATION ADMINISTRATION RECORD

ST0701

[illegible]

MEDICATIONS		HOUR		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30		
NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE																																			
CHARTING FOR 05/01/04 THROUGH 05/31/04																																			
Physician		Donnie		Telephone No.		Medical Record No.																													
Alt. Physician				Alt. Telephone		209 921																													
Nergies		N/A		Rehabilitative Potential																															

Diagnosis			
Procedure Number		Medicare Number	Complete Entries Checked
PATIENT <i>Boyd, Courtney</i>		By: <i>D Austin</i>	Title: <i>Lpn</i>
P		PATIENT CODE	ROOM NO
BED		FACILITY	
		<i>At.</i>	